SECOND REGULAR SESSION

HOUSE BILL NO. 1799

97TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE JONES (50).

5571L.01I D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 376.1363 and 376.1367, RSMo, and to enact in lieu thereof two new sections relating to health insurance benefit determinations for serious and urgent conditions.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Sections 376.1363 and 376.1367, RSMo, are repeated and two new sections enacted in lieu thereof, to be known as sections 376.1363 and 376.1367, to read as follows:

376.1363. 1. A health carrier shall maintain written procedures for making utilization review decisions and for notifying enrollees and providers acting on behalf of enrollees of its decisions. For purposes of this section, "enrollee" includes the representative of an enrollee.

2. For initial determinations, a health carrier shall make the determination within **[**two working days**]** **twenty-four hours** of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required:

(1) In the case of a determination to certify an admission, procedure or service, the carrier shall notify the provider rendering the service by telephone or electronically within twenty-four hours of making the initial certification, and provide written or electronic confirmation of a telephone or electronic notification to the enrollee and the provider within two working days of making the initial certification;

(2) In the case of an adverse determination, the carrier shall notify the provider rendering the service by telephone or electronically within twenty-four hours of making the adverse determination; and shall provide written or electronic confirmation of a telephone or electronic

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

notification to the enrollee and the provider within one working day of making the adverse determination.

3. For concurrent review determinations, a health carrier shall make the determination within one working day of obtaining all necessary information:

(1) In the case of a determination to certify an extended stay or additional services, the carrier shall notify by telephone or electronically the provider rendering the service within one working day of making the certification, and provide written or electronic confirmation to the enrollee and the provider within one working day after telephone or electronic notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services;

(2) In the case of an adverse determination, the carrier shall notify by telephone or electronically the provider rendering the service within twenty-four hours of making the adverse determination, and provide written or electronic notification to the enrollee and the provider within one working day of a telephone or electronic notification. The service shall be continued without liability to the enrollee until the enrollee has been notified of the determination.

4. For retrospective review determinations, a health carrier shall make the determination within thirty working days of receiving all necessary information. A carrier shall provide notice in writing of the carrier's determination to an enrollee within ten working days of making the determination.

5. A written notification of an adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. A health carrier shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and who requests such information.

6. A health carrier shall have written procedures to address the failure or inability of a provider or an enrollee to provide all necessary information for review. In cases where the provider or an enrollee will not release necessary information, the health carrier may deny certification of an admission, procedure or service.

376.1367. When conducting utilization review or making a benefit determination for emergency services **or health care services involving serious and urgent conditions**:

(1) A health carrier shall cover emergency services necessary to screen and stabilize an enrollee and shall not require prior authorization of such services;

(2) **A health carrier shall cover services for a serious and urgent condition, as defined in this section. For purposes of this section, "serious and urgent condition" means**

a patient's condition or diagnostic information which would lead a reasonably prudent licensed health care provider to determine that:

(a) The patient has inadequately controlled undiagnosed pain;

(b) A delay in diagnosis may cause disease progression, impairment to a bodily function, or serious dysfunction of any bodily organ or part; or

(c) A delay in providing diagnostic testing will result in the patient's health being at serious risk or jeopardy of harm;

(3) Coverage of emergency services **and serious and urgent conditions** shall be subject to applicable co-payments, coinsurance and deductibles;

[(3)**] (4)** When an enrollee receives an emergency service **or services for a serious and urgent condition** that requires immediate post evaluation or post stabilization services, a health carrier shall provide an authorization decision within sixty minutes of receiving a request; if the authorization decision is not made within thirty minutes, such services shall be deemed approved.

✓